MDR Tracking Number: M5-04-2071-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-11-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the massage, myofascial release, neuromuscular re-education, therapeutic procedure, and hot/cold packs were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 6-19-03 to 8-6-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

On 10-21-04, the requestor submitted a withdrawal letter for all services rendered on 7-25-03 and for code 97010 for dates of service 7-18-03, 7-20-03, and 7-23-03.

This Decision is hereby issued this 22nd day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-2071-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. L

May 24, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

This is a 48 year old lady with a long history of thoracic and lumbar area low back pain. There are notes indicating that the spinal injury goes back to ___. The reported mechanism of injury was that the driving a forklift and a lumbar strain was noted. Electrodiagnostic testing did not objectify a verifiable radiculopathy. ON the June 19, 2003 visit, Dr. M wanted to update the 10/14/98 MRI that noted a disc lesion. The physical therapy notes indicate repeated soft tissue modalities with no change in condition. Dr. M focused on obtaining a discogram. While this issue was being resolved, massage and other soft tissue passive modalities were continued. Repeat MRI imaging noted several degenerative disc lesions.

REQUESTED SERVICE(S)

Massage, myofascial release, neuromuscular reeducation, therapeutic procedure, hot or cold packs.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The reported mechanism of injury does not support the reported injury sustained. Moreover, the use of passive modalities more than eight weeks after the date of injury is not indicated. Additionally, with any therapeutic regimen, there should be a positive response if that methodology is to be continued. The physical therapy notes clearly indicate a status quo, and no improvement was noted with repeat treatment. At most, the care was subjectively palliative. Lastly, as noted by Dr. M, the injury being evaluated, as noted by the repeat request for discogram, was a disc lesion dating back to ___ Therefore, the treatment currently being rendered is not reasonable and necessary care for the injury sustained, this was addressing an eight year old event. In short, there was no efficacy to this treatment plan, noted after a short period, this was not addressing the actual injury sustained, and was only being used as a substitute while attempting to adjudicate another issue, making this not appropriate care.